Ellsworth School Department

Statement of Declination of ESD Health Insurance Coverage and

Attestation of Coverage of Self and Dependents for Teachers

Name: _____ Date: _____

School: _____ Position: _____

Please check all that apply:

_____ I decline the health insurance coverage offered to me by the Ellsworth School Department.

_____ I and all other individuals for whom I reasonably expect to claim a personal tax exemption for the taxable year(s) that begin or end with my employer's health plan year have or will have the minimum essential coverage required by law (other than coverage in the individual market) during the period to which the cash in lieu of payment applies.

_____ I acknowledge that the cash in lieu of payment will not be made to me if my employer knows or has reason to know that I or any other member of my expected tax family does not have (or will not have) the minimum essential coverage required by law.

_____ _____

Signature **Date**